

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005633	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/10/2012
NAME OF PROVIDER OR SUPPLIER MEMORIAL SPINE AND NEUROSCIENCE CENTER LL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 NAVARRE PL STE 4405 SOUTH BEND, IN 46601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005633</p> <p>Survey Date: 05/9 & 10/2012</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Karilyn Tretter, RN Public Health Nurse Surveyor</p> <p>Memorial Spine and Neuroscience Center, LLC, was found to be in compliance with 410 IAC 15.2, Ambulatory Surgery Center Licensure Rules.</p> <p>QA: cloughlin 06/20/12</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE